The Patient Placement Criteria (PPC) of the American Society of Addiction Medicine (ASAM) was first published in 1991 (Hoffmann, Halikas, Mee-Lee, & Weedman, 1991) and was generally designed for programs that offered only addiction treatment services. However, the ASAM PPC has always acknowledged the existence of co-occurring mental health problems in populations of persons with substance use disorders, consistent with seeing comorbidity as an expectation rather than an exception (Minkoff, 2001). That is why the inclusion of Dimension 3, Emotional, Behavioral Conditions and Complications, as one of the six assessment dimensions, in 1991, emphasized the need for programs and practitioners to address a person’s mental health needs. Dimension 3 was just as important to assess and consider in treatment and placement decisions as Dimension 1, Acute Intoxication/Withdrawal Potential.

Despite this awareness and sensitivity to the needs of dual diagnosis clients, the second edition of the ASAM Criteria, published in 1996 (ASAM PPC-2, 1996), still did not provide specific criteria for individuals with co-occurring mental and substance disorders. It was not until the revised second edition, Patient Placement Criteria for the Treatment of Substance-Related Disorders, ASAM PPC-2R, (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, eds. 2001) that the ASAM Criteria went further to help practitioners determine the appropriate type of treatment services to match the severity/stability of mental health problems.

**Terminology**

The addiction and mental health fields have used a variety of terms to describe individuals who are experiencing concurrent substance and mental health problems — co-occurring, co-morbid, dually diagnosed. The ASAM PPC-2R adopted the increasingly prevalent term “Co-Occurring Mental and Substance-Related Disorders” in formal descriptions of criteria. It also is a term that is consistent with the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, DSM-IV-TR*, (APA, 2000). Throughout the text of the ASAM PPC-2R, however, the term “dual diagnosis” is also used because it still has the widest recognition nationally.

One significant change in ASAM PPC-2R was to expand the understanding of Dimension 3 to Emotional, Behavioral, or Cognitive Conditions and Complications. This heightens awareness to assess an individual’s cognitive functioning as well as emotions and behavior. There may be delirium or dementia, or developmental disorders such as mental retardation or learning disabilities.
**Description of dual diagnosis services**

Throughout the adult criteria in the ASAM PPC-2R, treatment programs are described as generally of two types — Dual Diagnosis Capable (DDC) or Dual Diagnosis Enhanced (DDE) — to reflect their ability to address co-occurring substance-related and mental disorders. DDC programs have a primary focus on the treatment of substance-related disorders, but also are capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health problems related to an emotional, behavioral or cognitive disorder. DDE programs, by contrast, are designed to treat patients who have more unstable or disabling co-occurring mental disorders in addition to their substance-related disorders.

A third category is described, but no specific criteria are provided. ASAM PPC-2R promotes a view that all individuals, programs and health systems that provide treatment for addictive disorders should be prepared to serve the needs of dual diagnosis patients, at least to the extent described as DDC. Programs not ready to do so are described as providing Addiction-Only Services (AOS) that have the following characteristics:

- cannot accommodate patients with psychiatric illnesses that require ongoing treatment, however stable the illness and however well functioning the individual
- the policies and procedures of AOS programs typically do not accommodate co-occurring mental disorders. For example, individuals on psychotropic medications generally are not accepted; coordination or collaboration with mental health services is not routinely present; and mental health issues are not usually addressed in treatment planning or content.

On the contrary, DDC programs:

- routinely accept individuals who have co-occurring mental and substance-related disorders
- can meet such patients' needs so long as their psychiatric disorders are sufficiently stabilized and the individuals are capable of independent functioning to such a degree that their mental disorders do not interfere with participation in addiction treatment

- address dual diagnoses in their policies and procedures, assessment, treatment planning, program content, and discharge planning
- arrange for coordination and collaboration with mental health services; provide psychopharmacologic monitoring and psychological assessment and consultation onsite, or by well-coordinated consultation off-site.

As increasing numbers of addiction and mental health systems embrace the importance of addressing co-occurring disorders, there have been strong moves to develop more integrated, rather than sequential or parallel services. With that in mind, ASAM PPC-2R describes and provides criteria for DDE programs that provide a model for integrated services

- DDE programs can accommodate individuals with dual diagnoses who may be unstable or disabled to such an extent that specific psychiatric and mental health support, monitoring and accommodation are necessary in order for the individual to participate in addiction treatment.
- Such individuals are not so unstable
or impaired as to require primary psychiatric, acute 24-hour care and stabilization.

- Psychiatric and mental health clinicians as well as addiction treatment professionals staff DDE programs. Cross-training is provided to all staff. Such programs tend to have relatively high ratios of staff-to-patients and provide close monitoring of those who demonstrate psychiatric instability and disability.

- DDE programs typically have policies, procedures, assessment, treatment planning and discharge planning that accommodate people with dual diagnoses.

- Dual diagnosis-specific and mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies are more likely to be available (particularly in outpatient settings).

- Ideally, there is close collaboration or integration with a mental health program that provides crisis back-up services and access to mental health case management and continuing care.

To enhance practitioners’ ability to meet the diverse needs of those with co-occurring Axis I substance-related disorders and Axis I/II mental disorders, such individuals can be conceptualized as belonging to one of two general categories:

- Moderate Severity Disorders: Such persons present with stable mood or anxiety disorders of moderate severity (including resolving bipolar disorder); or with personality disorders of moderate severity (although some persons with severe levels of antisocial personality disorder may be appropriately placed in this group); or with signs and symptoms of a mental health disorder that are not so severe as to meet the diagnostic threshold.

- High Severity Disorders: Such persons present with schizophrenia-spectrum disorders, severe mood disorders with psychotic features, severe anxiety disorders, or severe personality disorders (such as fragile borderline conditions).

Individuals whose cooccurring mental disorders best fit within the category of moderate severity disorders are appropriately treated in DDC programs. Those with concurrent high severity mental disorders, on the other hand, generally are best managed in DDE programs. Some patients may require immediate stabilization of their psychiatric symptoms before they can be engaged in ongoing addiction treatment and recovery. Depending on the severity of their symptoms, such patients may require referral to medical and/or psychiatric services outside the ASAM PPC-2R levels of care (Mee-Lee & Shulman, 2003).

### Assessing Dimension 3

An important dimension to consider in treatment and placement decisions is to assess a person’s emotional, behavioral and cognitive functioning. In a more general sense, dual diagnosis assessment and treatment involves consideration of a diagnosable mental disorder or mental health problems that do not present sufficient signs and symptoms to reach the diagnostic threshold. The kinds of assessment questions to consider encompass:

- Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create or complicate treatment (e.g., depression that affects concentration and energy to get to recovery support groups)?

- Are there chronic conditions that affect the addiction treatment (e.g., chronic psychotic functioning)?

- Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous? Even if connected to the addiction, are they

### Matching Clients with Co-Occurring Disorders to Services

<table>
<thead>
<tr>
<th>Characteristics of Co-Occurring Disorders</th>
<th>Clients</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Addiction-Only Clients</strong>: Individuals who exhibit substance abuse or dependence problems without co-occurring mental health problems or diagnosable Axis I or II disorders</td>
<td></td>
<td><strong>Addiction Only Services (AOS)</strong>: Services directed toward the amelioration of substance-related disorders without services for the treatment of co-occurring mental health problems or diagnosable disorders. Such services are clinically inappropriate for dually diagnosed individuals.</td>
</tr>
<tr>
<td><strong>Clients with Co-Occurring MH Problems of mild to moderate severity</strong>: Individuals who exhibit (1) subthreshold diagnostic (i.e., traits, symptoms) Axis I or II disorders, or (2) diagnosable but stable Axis I or II disorders (e.g., bipolar disorder but compliant with and stable on medication)</td>
<td></td>
<td><strong>Dual Diagnosis Capable (DDC)</strong>: Primary focus on substance use disorders but capable of treating clients with sub-threshold or diagnosable but stable Axis I or II disorders. Psychiatric services available on-site or by consultation; at least some staff are competent to understand and identify signs and symptoms of acute psychiatric conditions.</td>
</tr>
<tr>
<td><strong>Clients with Co-Occurring MH Problems of moderate to high severity</strong>: Individuals who exhibit moderate to severe diagnosable Axis I or II disorders, who are not stable and require mental health as well as addiction treatment</td>
<td></td>
<td><strong>Dual Diagnosis Enhanced (DDE)</strong>: Psychiatric services available on-site or closely coordinated; all staff cross-trained in addiction and mental health and are competent to understand and identify signs and symptoms of acute psychiatric conditions and treat mental health problems along with the substance use disorders. Treatment for both MH and substance disorders is integrated. This service is most similar to a traditional “dual diagnosis” program.</td>
</tr>
</tbody>
</table>
severe enough to warrant specific mental health treatment (e.g., so depressed about an impending job and relationship loss due to addiction that client is preoccupied and can’t concentrate on recovery)?

- Is the patient suicidal or homicidal, and if so, what is the lethality?
- Is the patient able to manage the activities of daily living (e.g., Is he or she bathing, eating, or so dysfunctional that sleeping under the bridge is dangerous in the middle of winter)?
- If the patient has been prescribed psychotropic medications, is he or she adhering to the medication regimen?

In the adolescent criteria, separate from the adult criteria, there are five subdomains within Dimension 3 that have been added to improve assessment and targeting the treatment more specifically.

- **Dangerousness/Lethality:** This domain describes how impulsive an individual may be with regard to homicide, suicide, or other forms of harm to self or others and/or to property. The seriousness and immediacy of the individual’s ideation, plans, and behavior — as well as his or her ability to act on such impulses — determine the patient’s risk rating and the type and intensity of services he or she needs.

- **Interference with Addiction Recovery Efforts:** This describes the degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral, and/or cognitive problems and, conversely, the degree to which a patient is able to focus on addiction recovery.

- **Social Functioning:** This domain describes the degree to which an individual’s relationships (e.g., coping with friends, significant others or family; vocational or educational demands; and ability to meet personal responsibilities) are affected by his or her substance use and/or other emotional, behavioral, and cognitive problems.

- **Ability for Self Care:** This describes the degree to which an individual’s ability to perform activities of daily living (such as grooming, food and shelter) are affected by his or her substance use and/or other emotional, behavioral, and cognitive problems.

- **Course of Illness:** This employs the history of the patient’s illness and response to treatment to interpret the patient’s current signs, symptoms, and presentation, and predict the patient’s likely response to treatment.

Thus, the domain assesses the interaction between the chronicity and acuity of the patient’s current deficits. A high-risk rating is warranted when the individual is assessed as being at significant risk and vulnerability for dangerous consequences either because of severe, acute life-threatening symptoms, or because a history of such instability suggests that high intensity services are needed to prevent dangerous consequences.

For example, a patient may present with medication adherence problems, having discontinued antipsychotic medication two days ago. If a patient is known to rapidly decompensate into acute psychosis when medication is stopped, his or her severity is high. However, if it is known that he or she slowly isolates without any rapid deterioration when medication is stopped, the risk rating would be less. Another example could be the person who has been depressed, socially withdrawn, staying in bed and not bathing. If this has been a problem for six weeks, the severity is much higher than for a person who has been chronically withdrawn and isolated for several years with a severe and persistent schizophrenic disorder.

**Implications for treatment and placement**

What kind of program and in what level of care depends on what has been found in the Dimension 3 assessment. Firstly, is there a separate diagnosable mental disorder that requires specific mental health treatment expertise? Or can addiction counselors who are sensitive to mental health concerns, but not specifically trained in mental health, adequately address the mental health issues? Then, depending on the severity and level of stability of the Dimension 3 concerns, a decision can be made about a DDC versus a DDE service.

Within the ASAM PPC-2R, there are specific criteria listed under DDC and DDE for each level of care and even for assessment dimensions other than Dimension 3. The level of function in other dimensions also determines the treatment needs and therefore the type and intensity of the service level. Dimension 4, now called Readiness to Change in ASAM PPC-2R rather than its old name of Treatment Acceptance/Resistance; and Dimension 5, now expanded to Relapse, Continued Use, or Continued Problem Potential, are both applicable to mental health as well as to substance use disorders. That is true also for Dimension 6, Recovery Environment.

For example, a person may be ready to change their substance use, but not ready to accept mental health issues or vice versa. Another may be at risk for relapse of their mental disorder, but not the substance problem or vice versa. A person’s recovery environment may be toxic to either the substance use disorder or the mental disorder or both; or very supportive of either or both.

**A case example**

Kim is a 29-year-old, Caucasian, single mother, unemployed woman who was referred because of depression with suicidal and homicidal ideation, but no specific plan or means to follow through. She appeared depressed and had made verbal threats towards the Child Protective Services office as well as suicidal threats and feelings, if she did not get her children back.

Two months earlier, her two sons were put in a foster home because she allegedly left them unattended. She says that her boyfriend of 14 years actually pushed her down some steps and she fell and was unconscious for four days. She had taken
two hits of crystal methamphetamine and says that as a result of the "dirty" urine test, her children were taken away from her and she is very angry and depressed about this. Her boyfriend, who is now in jail for parole violation, is apparently being charged with attempted murder because of the incident.

Kim has been depressed over wanting her children back and angry at "the system" because she feels she has been wronged. She says that she has not used any drugs for nearly three years — other than one day two months ago — and claims she was very active in Alcoholics Anonymous (AA), having a sponsor and being involved up until eight months ago. Kim drifted away from AA and feels that this may have caused her relapse two months earlier. She wants to get her life together but also has been feeling angry about the difficulty of getting public assistance and has been making verbal threats of wanting to "blow people's brains out" and also feelings of wanting to give up and "that she is cracking up."

Kim denies any current use of alcohol or other drugs although admits in the past to having had a significant problem with cocaine and marijuana. She has had a previous psychiatric hospitalization four years ago, when she had cut her wrists and needed a couple of sutures after an argument with her boyfriend. She has been having no trouble with sleep and has had an increased appetite with a slight increase in weight, but her energy and libido have been decreased. She has been having some trouble with constipation, poor hearing in her left ear and occasional headaches, perhaps related to the fall two months ago. She does want help, however, mainly though to get her children back.

**Dimension 1**, Intoxication/Withdrawal: past history of detoxification, but no current use or withdrawal signs or symptoms.

**Dimension 2**, Biomedical: not on any medications, but has had some hearing problems in her left ear and occasional headaches over the past two months.

**Dimension 3**, Emotional/Behavioral/Cognitive: complex problems with the suicidal and homicidal thoughts, anger, energy and libido decrease, frustration; and history of previous psychiatric hospitalization for wrist cutting. No plan or means to harm self or others.

**Dimension 4**, Readiness to Change: wants help, but most focused on getting her children back and getting the system off her back. Agrees to come to treatment, but doesn’t want any inpatient treatment.

**Dimension 5**, Relapse/Continued Use/Continued Problem Potential: not clear how she will deal with any impulses to hurt herself or others, but wants to cooperate and agrees and feels able to call the crisis line or come in for help before acting on any impulses.

**Dimension 6**, Recovery Environment: lives in assisted housing alone, and has few friends and relatives who care about her. Unemployed with financial problems. No pending legal problems. Has a social worker assigned to her case who is concerned, but has a conflicting relationship with client.

**Discussion of case**

The severity in Dimensions 1 and 2 is low and no detoxification or intense physical health services are needed at present. In Dimension 3, Kim has no plan or means to harm herself or others. However, her history of impulsivity and current level of distress over her children indicates a level of instability perhaps beyond the ability for a DDC program to safely manage.

There are additional concerns in Dimension 4, as Kim is more focused on blaming others than focused on her own functioning; and in Dimension 5, she is unclear about how to deal with harmful impulses. The combination and interaction of the severity in Dimensions 3, 4 and 5 suggest a DDE program that can address the unstable Dimension 3 problems, as well as engage her into owning her part of the problems for Dimension 4 and developing some impulse coping strategies for Dimension 5.

In Dimension 6, since Kim does have a living situation free of actively toxic influences, is not wanting an inpatient setting; and has a concerned case worker, it is reasonable to initiate treatment in a Level II.5, Partial Hospital, DDE service.

**Conclusion**

Over the past decade, the ASAM PPC has promoted a common language of assessment and multidimensional criteria that has influenced addiction treatment not only in the United States, but also throughout the world in U.S. military bases. Now, with the publication of ASAM PPC-2R and the beginning of the second decade, the behavioral health field also has the opportunity for a common language that can unite services and systems to better integrate care for those with co-occurring disorders. 

---

**David Mee-Lee, M.D.** is Chief Editor of ASAM PPC-2R and is based in Davis, Calif., from which he is involved in full-time training and consulting. For more information visit [www.DMLMD.com](http://www.DMLMD.com); call (530) 753-4300; E-mail: DAVMEELEE@aol.com.
References


